

Criteria for Participation Phase-In Utilization Management

Substantial compliance with the following criteria will be necessary to participate as a Phase-In program under the NC UM/UR statewide program. Elements 1-7 are cross-walked from the DMA RFP.

1.0 The Agency must have a Utilization Management Plan that incorporates the following:

1.1 Purpose

1.2 Scope

1.3 Goals

1.4 Program Structure

- A Medical Director must provide oversight.
- The UM Department must maintain records, reports and supporting documentation of authorizations, denials, appeals, and reviews pursuant to record retention requirements.
- The UM Department must have sufficient staff and expertise to support the functions described in the plan. There must be at least one licensed/certified Staff for each population group served by the agency. In addition staff must be available that have special expertise with children and the elderly and have received training in cultural competency specific to key ethnic groups within their community. The agency will not be expected to conduct UR for Developmental Disabilities services.
- The Agency, at the request of DMA or upon a problem identified by the UM department, must have the ability to conduct special team reviews. The Agency will designate and dispatch a two- member on-site team with a clinical psychologist and a second professional representing the disability of the individual when investigation is required. DMA may request no more than five (5) and no less than two special reviews per year. The Agency may be required to add additional professionals to the special review team to the needs of the individual situation.

1.5 Methods for Notification of Decision & Grievances & Appeals

- Advance & Adequate Notice
- Denial of Access
- Suspension, Reduction or Termination Responsiveness

1.6 A mechanism for Medical Director Review and sign off on all denials and other guidelines and medical necessity requirements. A procedure for care management that includes seeking specialist services needed but not available in the network, monitoring clients as they transition from one level of care to another

2.0 Responsiveness

2.1 The Agency must be able to demonstrate timely response to authorization requests (3 days) at the 95% confidence level. A procedure for timely response to routine authorization requests that results in an approved, pending, or rejected notice pursuant to a PCP that has clearly stated outcomes, specifies community and natural supports, meets medical necessity requirements, demonstrates care will be provided according to the state's service definitions and best practice models and protocols.

2.2 The Agency must be able to review re-authorization requests within 2 days prior to the expiration of the previous authorization.

- The Agency must have sufficient capacity to answer all calls within 5 rings @95% and to return provider calls within 2 hours during regular business days. A procedure for timely (3 days) response to routine authorization requests that results in an approved, pending or rejected notice pursuant to a PCP that has clearly stated outcomes, specifies community and natural supports, meets medical necessity requirements, demonstrates care will be provided according to the state's service definitions, and best practice models and protocols.
- The authorization includes:
 - An effective date and an end date for the service authorized
 - The scope of service (definition and route of delivery) authorized
 - The amount – frequency and duration of service authorized

3.0 Performance

3.1 The Agency must have procedures for improving provider performance and assessment of client and provider satisfaction with the UM process.

3.2 The Agency must have a training plan on UM processes for providers

3.3 The Agency must have a staff representative to deal with provider complaints and problems during working hours and shall maintain a log of all calls

3.4 The Agency must have a staff person assigned to coordinate this effort with the Division.

4.0 The Agency must have a claims investigation process:

- The claim was authorized
- The service was in the person-centered plan
- The service was provided by an appropriately qualified individual
- The service duration and intensity matched the authorization
- The service was appropriately coded

- 5.0** The Agency must be able to demonstrate UR responsibility for all services in their catchments area except
- Admission & concurrent review for inpatient
 - PRTF
 - Criterion 5
 - Out of state services
 - Retrospective reviews for services delivered pre Medicaid eligibility
 - Post payment reviews for services already reimbursed to the provider

6.0 Receipt and transmission of documents and data

- 6.1** The Agency must have the ability to process, submit and receive by fax, trackable mail or electronic submission the written reports and notices regarding requests and review information.

- 6.2** The Agency must be able to receive and submit claims and cost summary system.

- 6.3** The Agency must submit annual, quarterly and monthly reports to the Division as specified including varying comparative analyses by service code, diagnosis, denials, authorizations, response time and appeals.

- 6.4** The Agency will comply with requests for information related to post payment and quarterly reviews from the state vendor.

- 7.0** Priority consideration will be given to Agencies having implemented these processes at least 6 months prior to this application.

Items 8-11 are cross-walked from the DMH Performance contract

- 8.0** The Agency must have met all requirements of the current LME Contract.

- 9.0** The Agency will have a process for Screening, Triage, & Referral. Authorization designed to facilitate a thorough evaluation for emergent and urgent care and necessary treatment; or for a routine assessment by a provider to enable the PCP to occur

- 10.0** The Agency will ensure choice of provider

- 11.0** The Agency will have a procedure for care management that includes seeking specialist service needed but not available in the community of providers, monitoring clients as they transition from one level of care to another.